# What is Care?

Smith, Mark

*Publication date:*
2021

*Document Version*
Publisher's PDF, also known as Version of record



*Citation for published version (APA):*
Smith, M. (2021). *What is Care?* (Common Weal Policy). Common Weal.

30.10.21

Common Weal Policy

# WHAT IS CARE?

# COMMON WEAL

Common Weal is a Scottish ‘think and do tank’ which promotes thinking, practice and campaigning on social and economic equality, participative democracy, environmental sustainability, wellbeing, quality of life, peace, justice, culture and the arts.

Common Weal is entirely funded by small donations from members of the public and is entirely independent of any political party. It is governed by a Board drawn from across the spectrum of progressive politics in Scotland.

Common Weal also has a network of autonomous local groups who seek to put Common Weal ideas into practice in their communities.

For more information visit:
www.commonweal.scot

Or contact us at:
hello@common.scot

# AUTHOR

**Professor Mark Smith** was a practitioner and manager in residential child care settings for almost 20 years before entering academia. He taught a Masters programme in residential child care at the University of Strathclyde, was Senior Lecturer and Head of Social Work at the University of Edinburgh and is now Professor of Social Work a the University of Dundee.

# KEY POINTS

— Covid has changed the discussion about care, moving it on from the crude efficiency and cost priories of the 1980s and 1990s. This is a step forward but is insufficient; the approach is still largely managerial and bears little if any relationship with the widespread international body of academic work on care and how to make it successful.

— The current Scottish Government consultation contains no discussion of what care is, what it's for or how it would look and feel for those being cared for.

— Rights are entirely the wrong framework for care. Rights is a theory of justice rather than of care. Even if rights were an appropriate framework within which to deliver care, such an approach can only happen if mediated through caring relationships.

— And rights mean nothing if there is no ability to access them – either because of poorly-resourced services or because the individual is incapable of either fully understanding or taking action to ensure their rights are met (as is often the case in a care relationship, for example with children, adults with learning difficulties or those with dementia).

— Instead, care should be based on building and sustaining relationships with those who are cared for. This involves moral and emotional investment from workers. The culture of separating rational/intellectual factors from intuitive/ emotional ones in care in a false pursuit of 'professionalism' has harmed relational approaches to care and instead promoted instrumental ones.

— Care theory moved on from managerial assumptions a long time ago but Scottish public policy has not. Only sustained, caring relationships are capable of accurately assessing and meeting this change. You cannot separate emotional and intuitive approaches to care any more than you could remove rational and skillsbased approaches.

— Care is not 'an intervention', it is a continuous series of relationships we all have in many different settings, most of them informal. You can't deliver

formal care without recognising and working with the reality of informal care, whether familial or community-based.

— Care is also political. It is impossible to separate the care we experience formally or informally from the context of the services and policies in which these take place. This is recognised in the Nordic care model where the concept of care is explicitly 'an art and an act' structured around good public services and localised delivery.

— The Scottish Government has set 'flourishing' as an objective for those in receipt of formal care but has not engaged with the academic literature of what 'flourishing' actually means or how it can be measured and assessed.

— Professional social work has, historically, been slow to adapt to new theories of care and is often stuck in the 'managerial' model, insufficiently focussed on relationships. This depersonalises care – we care because the rules say we must, not because professionals have a relationship with a person who needs care.

— This is in part because there is too much focus on 'protection' rather than care. Caring would take into account the concerns and needs of the individual while protection assumes bad intentions on the part of the individual and often fails to go beyond that. 'Caring about' outcomes is abstract; we need to 'care for' and 'care with' the specific person.

— The predominant orientation in care has become one of 'safety'. This is even more true of organisations and institutions than individuals. Fear of reputational risk is often a greater driver of policy and practice than the need to care is.

— This leads to risk-aversion in the workforce which, along with poor terms and conditions leading to high turnover and lack of proper training, creates a workforce incapable of delivering the right kind of long-term, relational care.

— There is no evidence that this regulatory approach has improved services but it has clearly disempowered professionals and carers. It is incentivising risk aversion much more than it is incentivising effective care approaches. This is not to argue there should be no accountability, but that it should be designed in a way that enhances the experience of care for people who need it and not the managers who manage it.

— The integration of care into health has dragged care further from its purpose; health and care are practices based on different orientations towards knowledgeand the current dominance of health over care is harming the practices of care. Sometimes just 'being with' rather than 'doing to' is key to social care, but this can be less the case for health care.

— Current care policy (like health policy) takes insufficient account of inequality and the ability of different groups to access services based on personal circumstances and conditions. Its one-size-fits-all approach is anathema to relationally-based care.

# CONTENTS

# INTRODUCTION

Social care is, more than ever, a wicked social issue subject to intense political scrutiny. The Covid-19 pandemic has brought pre-existing problems into sharp relief. The pandemic has impacted social care priorities and practices around, for instance, care home visits with implications for staff and user experiences of care. The terrain on which social care operates is likely to continue to change in the post-Covid environment, shifting the balance between the provision of medical services and social care support. This could go either way; it could validate the contribution and make the case for improved resourcing of social care or it could lead to limited resources being focussed on acute medical services.

Current day thinking on social care is framed by the neoliberal political and economic ideologies that emerged over the course of the 1980s and 1990s. Based around principles of economy, efficiency and effectiveness, these commodified care and took it into the marketplace (Scourfield 2011). At another level, neoliberal ideology, emphasising as it does qualities of autonomy, competition and independence, failed to adequately recognise the relational dimensions of care within which dependency is often central (Steckley and Smith, 2011).

The pandemic prompted the Scottish Government to set up an Independent Review of Adult Social Care chaired by Derek Feeley, a former Scottish Government Director General for Health and Social Care and Chief Executive of NHS Scotland. Feeley states the need to 'shift the paradigm' and establish a new narrative on social care.

The recommendations of the Feeley Review were taken even further by the Scottish Government in their response to it. They proposed a National Care Service with the aim that "the country's social care system will consistently deliver high quality services to everyone that needs them, based around principles of human rights" (Scottish Government, 2021). The Scottish Government proposals set out a range of social groups recognised to be in need of care including those with physical disabilities, learning disabilities or mental health conditions, older people and those with dementia, people with or recovering from alcohol or drug addictions, those who are, have been or are at risk of being homeless, and children and families who may need additional support, or where children are unable to live with their own families. This makes much sense and holds out the possibility of a cradle to grave care service, within which common principles permeate practice at every level and with every client group. There are parallels here with the kind of vision for social work that emerged following the 1968 Social Work (Scotland) Act before the profession became fragmented into different specialisms (although, as is discussed later, social work never really came to terms with the idea of care).

Having recognised this broad range of care needs, the proposals themselves do little to shift the paradigm within which care is thought of or to move the debate beyond a neoliberal paradigm, based as they are around private sector financing models and new public management mantras of improvement. They also seek to centralise care provision with the Scottish Government, further eroding the role of local authorities in responding to community needs, and as such contrary to the principles of the Christie Committee (2011) , which called for services to be delivered as near as possible to communities.

But the major gap in the Review and subsequent Government proposals is that, in focusing on service delivery, they fail to engage with any idea of what it is that is to be delivered – what might this notion of care that is being promised look or feel like? Nor does the Review or Government proposals address related knowledge and identity issues among the workforce. The result of these failures to move beyond current inadequate understandings is that social care will continue to be conceived of as a largely instrumental task (often delivered in 15-30-minute blocks) and with a primary mandate around protection and safety. This hinders any development of the relational and, generally, the more life-enhancing aspects that ought to be central to care.

Supporting any wider conception of care demands a shift beyond managerial concerns to consider a philosophical rationale for care. There is a well-developed body of philosophical

literature on care, which is not recognisable in Feeley's or in the Scottish Government's proposals. In particular, the focus on rights, which is at the heart of and which seeks to furnish the proposals with some theoretical ballast, offers an inadequate paradigm within which to locate care, a point this paper returns to. The failure to engage with some of these deeper philosophical debates is likely to limit the range of possibilities that a National Care Service might offer. The intention of this paper is to outline some philosophical perspectives on care, with a Scottish flavour.

# CARE AS INSTRUMENTAL OR RELATIONAL

A key tension in any debate around care is around the balance between its rational and relational dimensions. Some of these tensions might be traced back to The Enlightenment, that period of major scientific and philosophical advance that swept Europe over the 18th Century. A key feature of the European Enlightenment was a turn to science and reason as ways through which to understand the human condition. The Prussian philosopher, Immanuel Kant (1998), became perhaps the key thinker in this regard. Kant proclaimed human beings to be rational, autonomous individuals who used reason to determine how they ought to behave. His deontological ethics stressed the quality of duty. His categorical imperative decreed that what was considered right in one situation should apply universally. From a Kantian perspective care might be thought of as a public duty (rather, arguably than a public good), which ought to be delivered equitably. While there is some merit in such a proposition it is also inadequate as it fails to appreciate a version of care that goes beyond duty to incorporate a purpose or end point to care or to recognise the particularist aspects of care relationships, which mean that they can't be the same for everyone.

Kantian principles have been incredibly influential since the Enlightenment and are a bedrock of dominant ideas of professionalism. The pursuit of objectivity, for instance, has seen care workers, under the guise of professionalism, seek to separate their rational/intellectual selves from their intuitive/emotional ones, splitting off the professional from the personal. Qualities of objectivity and detachment are encouraged, while emotional involvement with clients is seen as unprofessional. Such assumptions are problematic when it comes to care, where the personal and professional inevitably and rightly elide.

Interestingly, Scottish Enlightenment philosophers in particular, Hutcheson, Hume and Smith, raised questions about this wider turn to rationality - all identified an emotional or sentimental side to human nature named, variously as benevolence, sympathy or fellow feeling (see Hearn 2016). Hume went so far as to claim that reason was but a slave to the passions – that an emotional response when encountering another human being or when coming to decisions was primary. This quality of moral sentiment drew individuals to reach out to one another based, not on reason or self-interest, but on something more intrinsically human. This moral impulse was reprised in 20th Century philosophy. Levinas' (1979) ethics of encounter imagines humans as being drawn to 'the face', the unknowable essence of the other. For Levinas, ethics and specifically, the obligation and responsibility we hold for 'the other' precedes reason. The Scottish philosopher, John Macmurray, picked up on the tension between reason and emotion, arguing that excessive rationality acts to marginalise the role of emotions in the human condition. In a challenge to Kantian ethics, Macmurray (1961) conceives of human beings not as autonomous, rational individuals but as 'persons in relation', existing only by virtue of their relationships with one another. In a challenge to deontological ethics, Macmurray argues that care is not possible in terms of duty and obligation but must emerge as an ethic of love (see McIntosh, 2004).

Another feature of a Scottish approach to care can be discerned in the work of the Scottish human relations theorists, Fairbairn, Suttie and Sutherland (see Kirkwood, 2012; Miller, 2007) These writers brought together growing interest in psychiatry in the context of their own Presbyterianism. While Presbyterianism might be thought to have cast a questionable shadow over Scottish cultural life it also called its adherents to an idea of a

godly commonwealth and an obligation to act towards the common good – it was not merely individualistic but brought with it obligations to one's neighbours (see Sharpe, 2016).

# CARE ETHICS

Joan Tronto (1994), a seminal writer on care ethics argues that Scottish Enlightenment thinkers came out on the losing side in eighteenth century intellectual debates, when Kantian ideas became and have, largely, remained dominant. Nevertheless, the centrality of moral sentiment in its relationship to reason is re-emerging as a key theme in ethical thinking, as is evident in the heightened attention given to care ethics across a range of academic and professional disciplines.

Care (or feminist) ethics were first elaborated by Carol Gilligan (1982), who identified differential responses to moral dilemmas between men and women, the male voice being based around rules and reason and the female one drawing more on qualities of intuition and compassion. The male and female voices were seen as reflecting different moral orientations rather than being essentialised with men or women. Tronto, in her book ***Moral Boundaries*** (1994: 126) described care as "a practice, rather than a set of rules or principles". It is both an activity and a disposition, which in a social care context, might be understood in terms of practice that is not merely task-focussed in the sense of following procedure or doing one's duty, but is carried out in a manner that conveys a sense of care and of 'mattering' to the one cared for.

Care ethics eschew Kantian universalism, being bound to particular, concrete situations; what is the right or wrong thing to do in a situation depends on context (this observation might make a case for a greater localism than is conceived of in the Scottish Government's proposals). Care ethics also reject a purely rational approach, recognising the centrality of emotions in ethical deliberation and action. In that sense, Tronto (1994) identifies an explicit link from her conception of care ethics back to some of the central themes of Scottish Enlightenment thinking. She is careful, though, to recognise that good intentions are not enough and that caring also involves competence – being a caring person in itself does not necessarily lead to skilled caring practices around e.g. manual handling. On the other hand, skilled manual handling in the absence of a caring disposition is unlikely to be experienced as caring.

Other writers in the care ethics canon develop ideas of what care might be. Noddings (2002) identifies it as central to a notion of human flourishing, while Held (2006) argues that care presents us with a moral responsibility to provide for and respond to others. Care ethics appreciates the emotional and relational capabilities that enable the caregiver to understand what might be best to do at any one time, demonstrating a practical wisdom rather than merely following the rules. Moreover, care is not a unidirectional transaction, but reflects the engagement between inter-dependent and relational beings (Tronto and Fisher, 1990); it emerges out of the nature of the relationships that develop between the care giver and care receiver over time. This makes it difficult to standardise care as a managerial logic seeks to do; each care relationship will follow its own course.

Feder-Kittay (2003) recognises care as normative – it is a universal experience that happens in everyday contexts. As such, it is not confined to mandated or statutory care but is experienced in familial and neighbourly interactions and in informal settings such as pubs, cafes and hairdressers. And while the state cannot be expected to provide such sites or interactions, these, nonetheless, provide an important dimension to any more holistic understanding of care; it is not just something that is delivered by the state but happens all around us in everyday settings. The state needs to move away from the notion of care as statutory intervention and to work with the grain of such a wider ecology of care.

# A POLITICAL DIMENSION TO CARE

Care literature often distinguishes between an affective 'caring for' (consisting in direct, ongoing relationships with particular others) and

a more abstract 'caring about' our fellow citizens (Noddings, 1984). Both are required; caring about provides the political and societal context which allows the face-to-face work of 'caring for' to happen. However, Noddings (1984) goes on to suggest that caring about can involve a certain benign neglect and is empty if it does not result in caring relations. So, it is all very well to speak about care but there is also an imperative to get one's hands dirty at times in 'doing' care.

Tronto (2013) introduces a third dimension, that of 'caring with', which involves a wider orientation of solidarity fundamental for democracy. Indeed, Tronto's work has provided a platform for the development of a wider political ethic of care (see also Held, 2006), which recognises that care is not merely interpersonal but is facilitated or impeded by political decisions around, for instance, the provision of free child or personal care but also in the way that society values carers, both formal and informal, through the rights, protections and conditions of service offered them.

As I argue above, care needs to be recognised as a social good (Nussbaum, 2011). This is compromised by continuing to locate it within an economic system the primary motive of which is profit maximisation. Held (2006) argues that the ethics of care may be better equipped than traditional theories for guiding ethical thinking in global contexts, including addressing the limitation of market economies. Care ethics in this sense offer a counterpoint to the managerial direction of current and proposed care provision (Maegher and Parton, 2004).

## A Nordic model of care

The Scottish Government has intermittently claimed to aspire to a Nordic model of care and this does set out a more comprehensive care paradigm than that set out by Feeley. A Nordic tradition of care, which emerged from the 1990s onwards (Arman et al, 2015) incorporates the nature of care, the ethics of care and a knowledge base for care. Caring is seen as a natural phenomenon in which a care receiver's world, vulnerability, health, and suffering are primary. Caring is seen as both an art and an act (Arman et al, 2015). The literature also emphasises local solutions rather than general ethical principles (Mol et al. 2010), which might open up possibilities of care being delivered very differently – through local care co-operatives or hubs (see the report by Colin Turbett of the Common Weal Care Reform Group published as part of the work of the group towards developing a holistic care model for Scotland).

## Care as flourishing

The Scottish Government (2021) claims to want to change the care system 'from one that supports people to survive to one that empowers them to thrive'. There is literature that might expand what is meant by this. Influential writers (Sen, 1999; Nussbaum, 2011) develop what has become known as the capabilities approach to care. This focuses on human flourishing and emphasises the skills and resources required to flourish, not just survive (which is taken up in the Scottish Government's aspiration). If care should aspire to more than survival or the maintenance of a 'good enough' degree of functioning one of the prerequisites of this will be to enable care-receivers – and caregivers – to flourish as the individuals they are, within the relationships that are most important to them.

# SOCIAL WORK AND SOCIAL CARE

At a professional level, difficulties around care are amplified in the current political and economic climate. An extended period of austerity has left services depleted, local authorities struggling to meet their statutory obligations and a workforce under strain. But there is also a broader conceptual tension that emerges out of the uneasy relationship between social work and social care. As a profession, social work has always enjoyed a superordinate role within that relationship. This is problematic because social work has rarely engaged with the idea of care, basing much of its professional identity around promoting ideas of independence and empowerment. Care on the other hand recognises dependency and inter-dependency.

While care has rarely been central to social work there is, nevertheless, a growing body of writing that seeks to apply care ethics to social work contexts (Orme, 2002). Lloyd (2006) makes the case that ethics of care present a challenge to social workers with older people to re-assess the place of care within professional social work practice and to reappraise how concepts of justice, autonomy and rights are conceptualized and ageing is understood.

State care, however, for the most part struggles to move beyond its Kantian roots and in its quest to be seen as 'professional' rather than just 'everyday', it has devalued the moral, emotional and practical dimensions of care. Bubeck (1995: 231) claims that public care is 'shaped by the requirement of impartiality', and as such carers are expected not to allow relationships to influence their actions. A consequence is that there has been a privileging of tasks, based upon abstract managerial eligibility principles, over practical and relational encounters between carers and those cared for. This undermines the trust and indeed the affection upon which these relationships must be based (Held 2006).

Partly as a result of this predominant focus on task, state care and services commissioned by the state are often low on ambition. Contemporary public care services mandated to care often fail to 'care for' or 'with' people in any affective or moral sense: they may be impersonal, or inattentive, providing physical care but not caring care (Maier, 1979). There is an important philosophical point here. As Bauman (2000) argues, the more we surround everyday practices of care with evermore rules and regulations, the more we dissipate the primary moral impulse to care, the more we efface the face that Levinas asserts we are called to respond to. We act from a reductionist sense of duty – we care because the rules say we have to rather than through any deeper draw to do so.

Furthermore, social work professional identity has, in recent decades, formed around a primary concern for protection, beginning with child protection and more recently extended to adult protection. Again, care ethics provide an insight into the conceptual difficulties with this focus. Protection 'involves a very different conception of the relationship between an individual or group, and others than does care. Caring seems to involve taking the concerns and needs of the other as the basis for action. Protection presumes the bad intentions and harm that the other is likely to bring to bear against the self or group and to require a response to that potential harm. Protection can also become self-serving, turning into what Judith Hicks Stein calls a 'protection racket' in which the need for protection reinforces itself (Tronto 1994: 104-05). Social work has morphed, in recent decades, into a 'protection racket' within which laudable intentions to protect individuals have, in many cases, become the limit of the social work role, precluding any wider aspiration to promote flourishing.

## STATE CARE AND THE CARE WORKFORCE

A social care system that cared for or with its recipients would be characterised by stability and a sense of intrinsic and reciprocal reward from meeting emotional and practical needs, rather than the rapid staff turnover, excessive workloads (Crenna-Jennings, 2018) and risk aversion that characterise present-day care. In risk-averse climates, services are driven, largely, by procedural and task-oriented approaches, reflecting instrumental rather than relational care (Cottam, 2018).

The institutional logic of state social services has become one of safety, not just for recipients of services but arguably more so in respect of organisations avoiding reputational damage. Any progressive politics of social work 'is threatened as social workers confront the widening gulf between professional ideals and the realities of their practice within the morally conservative context of neoliberal risk society' (Stanford, 2011: 1514). Stanford goes on to recognise social workers' own sense of being 'at risk' (of disciplinary or regulatory action) within this wider cultural and organisational context. This sense of risk is reinforced by the regulatory apparatus that has emerged over the past two decades.

## Regulation

Feeley and the Scottish Government conceive of an enhanced regulatory function to govern the new National Care Service. Since The Regulation of Care Act (2001), care services have been regulated by the Care Commission (now the Care Inspectorate) and the workforce by the Scottish Social Services Council. Whilst a key justification for regulation was to enhance professional identity, there is little evidence that it has done so. Indeed, a growing literature points to conflictual and unproductive relationships between the social work and social care professions and their regulators, within which a marked power imbalance in favour of the regulator is apparent (Simpson et al 2020). More generally, there is no evidence that regulation has improved services. In that sense, regulatory systems might be seen as propagating themselves to little benefit for the care recipient or giver.

Central to this power imbalance between care workers and the regulators is the fitness to practise processes, which entail that workers are judged and potentially struck from the registration list if found wanting, often by panels of people  who know nothing of their practice and where "no body of knowledge, no evidence, no discrete idea or philosophy underpins the 'system' of regulation" (Haney, 2012). Those undertaking direct care tasks are far more likely to fall foul of such systems than those involved in more administrative tasks (Banks et al, 2020). It is not a state that is conducive to offering relational care, which involves risks of such care being misconstrued or identified as unprofessional. In fact, it provides an incentive to merely follow the rules and do the minimum that is required to avoid falling foul of the regulator.

Regulation, by its nature, locates good practice in external rules and threats of disciplinary action rather than within the internal sense of responsibleness (Green, 2009). It is this more intrinsic motivation to care and to care well that drives practitioners to achieve what MacIntyre (1984) identifies as internal goods or standards of excellence. In focussing on codified requirements, regulation privileges a narrow conception of ostensibly measurable effectiveness over any wider sense of excellence, which requires that practitioners think beyond codes and are guided by the needs of the concrete others that they care for.

To critique current systems of regulation is not to argue that carers should not be accountable for the care they offer – but there are other more local and developmental ways that this could happen. It is to question whether recourse to a regulatory model that is increasingly recognised as inadequate and, arguably, counter-productive to improving practice or enhancing the professional identity of care workers should form a central plank of current proposals.

## The knowledge base of care

There is another dimension implicated in the difficulty that social care workers can have in asserting a professional identity, which is to do with the knowledge base for social care. The failure to explore this and how it might differ from the types of knowledge required for other forms of work explains a lot in terms of the difficulties in valuing the sector but also casts some light on the pitfalls of attempting structural initiatives such as the integration of health and social care. That the health and social care integration agenda has been beset by difficulties is not merely or primarily down to poor management or leadership as can be posited, but more fundamentally reflects tensions around the different forms of knowledge that underpin the different fields of practice. While there is inevitable crossover, the different knowledge practices of health and social care reflect different academic roots: medical sciences and related science disciplines on the one hand and sociology, anthropology and philosophy on the other (Lloyd Richards 2020). Ignoring, or more likely being unaware of these will make the task of encouraging effective working between health and social care organizationally and on the ground all the more difficult.

Professional education in medical fields valorises cognitive and instrumental forms of knowledge, seeking to apply a 'scientific' knowledge of what is going on in a situation and follow this through with a clinical or medical intervention. The social care task does not lend itself to such a way of working. Garfat (1999) describes a central task of residential child care workers as 'hanging out'

with children. The idea applies across all client groups. 'Hanging out' involves just 'being with' someone rather than 'doing to' them; it might involve watching television or doing a crossword with them, listening to their stories, sharing a cup of tea (and knowing how many sugars someone might take). It may involve doing very little that is seen or spoken. Tronto (1994: 16) says that care requires that we recognise "unspoken needs, distinguishing among and deciding which needs to care about". In this sense, care involves intuition and discernment. In practice this may require that workers have sufficient autonomy to decide how to best divide and spend their time with people, giving those who need more attention more time when this is required and others less, rather than this being circumscribed by set time blocks.

Because one can't necessarily say how long it will take to complete a crossword or to measure the benefits of sitting watching television with someone, 'hanging out' is anathema to a managerial logic which seeks to parcel care into set tasks. 'Hanging out' is also problematic because it doesn't reflect the kind of 'scientific' knowledge that is seen by policy-makers to be more robust than social care knowledge with implications for the respective identities of workers in the different sectors; health professions are better regarded (and paid) than carers. Yet, overly scientific forms of knowledge are argued to be inadequate in 'people professions' (Bondi et al, 2011). Whan (1986: 244) argues that there is a need 'to define the daily encounter with clients not as a matter of technique or method but as practical-moral involvement'. Social care concerns the art and craft of everyday life (Lloyd Richards, 2020). It requires a practical rationality, within which the person and the disposition of the carer are central (Smith, 2020). This involves a different way of knowing which includes practical, embodied and reflexive knowledge (Kinsella 2001).

## CARE AND HEALTH INEQUALITIES

A further point in any political conversation about care is the connection between care and inequalities, a connection not sufficiently picked up in the proposals for a National Care Service. There is a clear link between social conditions and health outcomes, the magnitude of health inequalities being an indicator of the impact of social and economic inequalities on peoples' lives. These inequalities can be reinforced in the current situation in which those who are articulate or have articulate advocates are likely to be able to lay greater claim to care than those without such resources. This is particularly salient at the moment given concerns about drugs deaths but more generally, it is evident in the 'deaths of despair' that are only most pronounced in what has become known as 'the Glasgow Effect' but are apparent across Scotland. Care, then, needs to be understood in the context of inequalities of generation, knowledge, social status and esteem. But it also involves relational inequalities. In this regard, Lynch et al's (2016) work on 'affective inequality' is important as it links care relationships to social justice. Our life chances are highly influenced by the kind of care relationships we are able to call upon, partly because of the positive impact that affirming relationships have on esteem and functioning and partly as a result of the social capital that can accrue from such relationships. The distribution of care (Calder 2018) therefore requires interrogation.

## CARE AND RIGHTS

Feeley and the Scottish Government propose a care service based around rights. From a care ethics perspective, rights speak to a theory of justice rather than of care. The rights discourse, as it has developed in the anglophone world, is consistent with a wider neoliberal worldview (Harvey 2007). It reflects an "increasing recourse to law as a means of mediating relationships … premised on particular values and a particular understanding of the subject as a rational, autonomous individual" (Dahlberg & Moss 2005: 30), capable of entering into relationships that are broadly contractual.

Yet care should not be considered as contractual. It has its origins in early, unchosen and dependant parental relationships that cannot be

contractual. Care, as Noddings (2002) argues "starts at home"; early experience of care becomes the template for future caring, (which, again, might make the case for any National Care Service to apply across all client groups). Care of children must occur before the question of justice arises and must be assumed before questions of contractual rights become relevant. In this sense, care is more basic than justice – rights depend upon care and can only be mediated through relationships (Lloyd-Richards, 2020). Moreover, people are only motivated to recognise and respect the rights of others if they care for them in at least a minimal sense. Care ethics, in this sense, shift the way we think about care away from rules and rights towards relationships and responsibilities (Held, 2006).

But there is another, fundamental, problem with rights; they create a set of obligations and duties on those conferring the right (in this case the Scottish Government or any new body set up to manage the National Care Service). This implies that such institutional structures have the power and resources to enact or offer such a right. This takes no account of the wider economic context, which is one of austerity and strictly limited resources. The practical manifestation of this is that social workers may assess a need, which may then be framed as a right, but there will be no way to claim or certainly to avail of such a right. The only way to deal with this is to set rights at a minimalist level that may allow people to survive but cannot but fail to achieve any aspiration towards care that enables people to thrive. A rights-based approach will only raise expectations that cannot be met.

There are other banalities within a rights-based approach. What purpose is served by telling a dementing older person or someone with a severe learning disability that they have particular rights but no capacity to understand or claim such rights? Any such rights they may have can only be mediated through caring relationships, whether family or through skilled social care practice. This mediation takes the form of relatedness between the person with the obligation (or their proxy) and the person requiring care. This relationship is not simply a transactional one but realises and embodies a relational and social good in its performance (Lloyd-Richards, 2020).

# CONCLUSIONS

As the prospect of a National Care Service becomes imminent, it becomes all the more important that any such service is built on solid foundations. Early signs of this are not encouraging and merely reiterate calls for more effective structures or for a service based around human rights. Both approaches are fundamentally flawed and destined to fail. Any worthwhile National Care Service needs to start from a philosophical exploration of what care, across the lifecourse,is or might be. A starting point for this would be the need to move beyond rules and rights and to build a system based on a recognition of mutual responsibilities and the realisation of these through human relationships.

# REFERENCES

Arman, M., Ranheim, A., Rydenlund, K., Rytterström, P., & Rehnsfeldt, A. (2015). The Nordic tradition of caring science: the works of three theorists. Nursing science quarterly, 28(4), 288-296.

Banks, S., Zasada, M., Jago, R., Gallagher, A., Austin, Z., & van der Gaag, A. (2020). Social Workers under the Spotlight: An Analysis of Fitness to Practise Referrals to the Regulatory Body in England, 2014–2016. The British Journal of Social Work, 50(2), 326-347.

Bauman, Z. (2000). Special essay. Am I my brother's keeper?. European Journal of Social Work, 3(1), 5-11.

Bondi, L., Carr, D., Clark, C., & Clegg, C. (2011). Towards professional wisdom: Practical deliberation in the people professions. Farnham, Ashgate.

Bubeck, D. (1998). Ethic of care and feminist ethics. Women's Philosophy Review, (18), 22-46.

Calder, G. (2018). What Would a Society Look Like Where Children's Life Chances Were Really Fair?. Local Economy: The Journal of the Local Economy Policy Unit, 33(6), 655-666.

Cottam, H. (2018). Radical help: How we can remake the relationships between us and revolutionise the welfare state. Hachette UK.

Crenna-Jennings, W. (2018). Vulnerable children and social care in England: A review of the evidence.

Dahlberg, G. and Moss, P. [2005]. Ethics and politics in early childhood education. Oxfordshire: Routledge Falmer

Garfat, T. (1999). On Hanging Out. CYC-Online, October. pp 7-8.

Gilligan, C. (1982). In a different voice: Psychological theory and women's development. Harvard University Press.

Green, J. (2009). The deformation of professional formation: Managerial targets and the undermining of professional judgement. Ethics and Social Welfare, 3(2), 115-130.

Haney, J. (2018). Regulation in Action: The Health Professions Council Fitness to Practise Hearing of Dr Malcolm Cross-Analysis, History, and Comment. Routledge.

Harvey, D. (2007). A brief history of neoliberalism. Oxford University Press, USA.

Hearn, J. (2016). Once more with feeling: The Scottish Enlightenment, sympathy, and social welfare. Ethics and Social Welfare, 10(3), 211-223.

Held, V. (2006). The ethics of care: Personal, political, and global. Oxford: Oxford University Press.

Kant, I. (1998). Critique of Pure Reason. Trans. and eds. Paul Guyer and Allen Wood. Cambridge: Cambridge University Press.

Kinsella, E. A. (2001). Reflections on reflective practice. The Canadian Journal of Occupational Therapy, 68, 195– 198.

Kirkwood, C. (2012). The Persons in Relation Perspective. Sense Publishers, Rotterdam.

Kittay, E. F., & Feder, E. K. (Eds.). (2003). The subject of care: feminist perspectives on dependency. Rowman & Littlefield Publishers.

Levinas, E. (1979). Totality and infinity: An essay on exteriority (Vol. 1). Springer Science & Business Media.

Lloyd Richards, H. (2020) Unpublished paper

Lloyd-Richards, H (2020) Unpublished paper

Lloyd, L. (2006). A caring profession? The ethics of care and social work with older people. British Journal of Social Work, 36(7), 1171-1185.

Lynch, K., Baker, J., Lyons, M., Feeley, M., Hanlon, N., Walsh, J., & Cantillon, S. (2016). Affective equality: Love, care and injustice. Springer.

MacIntyre, A. (2013). After virtue. A&C Black.

Macmurray, J. (1961) Persons in Relation. London: Faber and Faber

Maier, H. W. (1979). The core of care: Essential ingredients for the development of children at home and away from home. Child care quarterly, 8(3), 161-173.

Mcintosh, Esther (ed.) (2004). John Macmurray: Selected Philosophical Writings_. Exeter, UK: Imprint Academic

Meagher, G. (2004). Modernising social work and the ethics of care. Social Work & Society, 2(1), 10-27.

Miller, G. (2008). Why Scottish 'personal relations theory' matters politically. Scottish Affairs, 62(1), 47-62.

Mol, A., Moser, I. and Pols, J. (2010). 'Care in Practice. On tinkering in Clinics, Homes and Farms, Bielefel: transcript Verlag

Noddings, N. (2002). Starting at Home. Caring and social policy, Berkeley: University of California Press.

Noddings, N. 1984. Caring: A feminine approach to ethics and moral education. Berkeley, CA: University of California Press.

Nussbaum, M. C. (2011) Creating Capabilities: The Human Developmental Approach. Cambridge, Harvard University Press.

Orme, J. (2002). Social work: Gender, care and justice. British Journal of Social Work, 32(6), 799-814.

Scottish Government (2011) Christie Commission on the future delivery of public services Christie Commission on the future delivery of public services - gov.scot (www.gov.scot)

Scottish Government (2021) Backing for Feeley Review Recommendations Backing for Feeley Review recommendations - gov.scot (www.gov.scot)

Scourfield, P. (2012). Caretelization revisited and the lessons of Southern Cross. Critical Social Policy, 32(1), 137-148.

Sen, A. (1992). Inequality reexamined. Oxford: Oxford University Press.

Sharpe, C. (2016). From the individual, to the relational and communal: the Kirk's influence on three Scottish thinkers: Ronald Fairbairn, John Macmurray and Ian Suttie. Ethics and Social Welfare, 10(3), 224-238.

Simpson, M. Daly, M. and Smith, M. (2020) ;The Social Work Regulator and Professional Identity: A Narrative of Lord and Bondsman', The British Journal of Social Work, Volume 50, Issue 6: 1909–1925

Smith M. (2020) "It really does depend: Towards an epistemology (and ontology) for everyday social pedagogical practice." International Journal of Social Pedagogy 9, no. 1: 1-18.

Stanford, S. (2010). 'Speaking back'to fear: Responding to the moral dilemmas of risk in social work

practice. British Journal of Social Work, 40(4), 1065-1080.

Steckley, L., & Smith, M. (2011). Care ethics in residential child care: A different voice. Ethics and Social Welfare, 5(2), 181-195.

Tronto, J. (2013). Caring Democracy: Markets, Equality, and Justice. New York: New York University Press.

Tronto, J. C & Fisher, B. (1990), Toward a Feminist Theory of Caring. in E Abel & M Nelson (eds), Circles of Care. SUNY Press, Albany, NY, pp. 36-54.

Tronto, J. C. (1994). Moral boundaries: A political argument for an ethic of care. Psychology Press.

Whan, M. (1986). On the nature of practice. The British Journal of Social Work, 16(2), 243-250.